HOUSE CALL
intercommunity hospital

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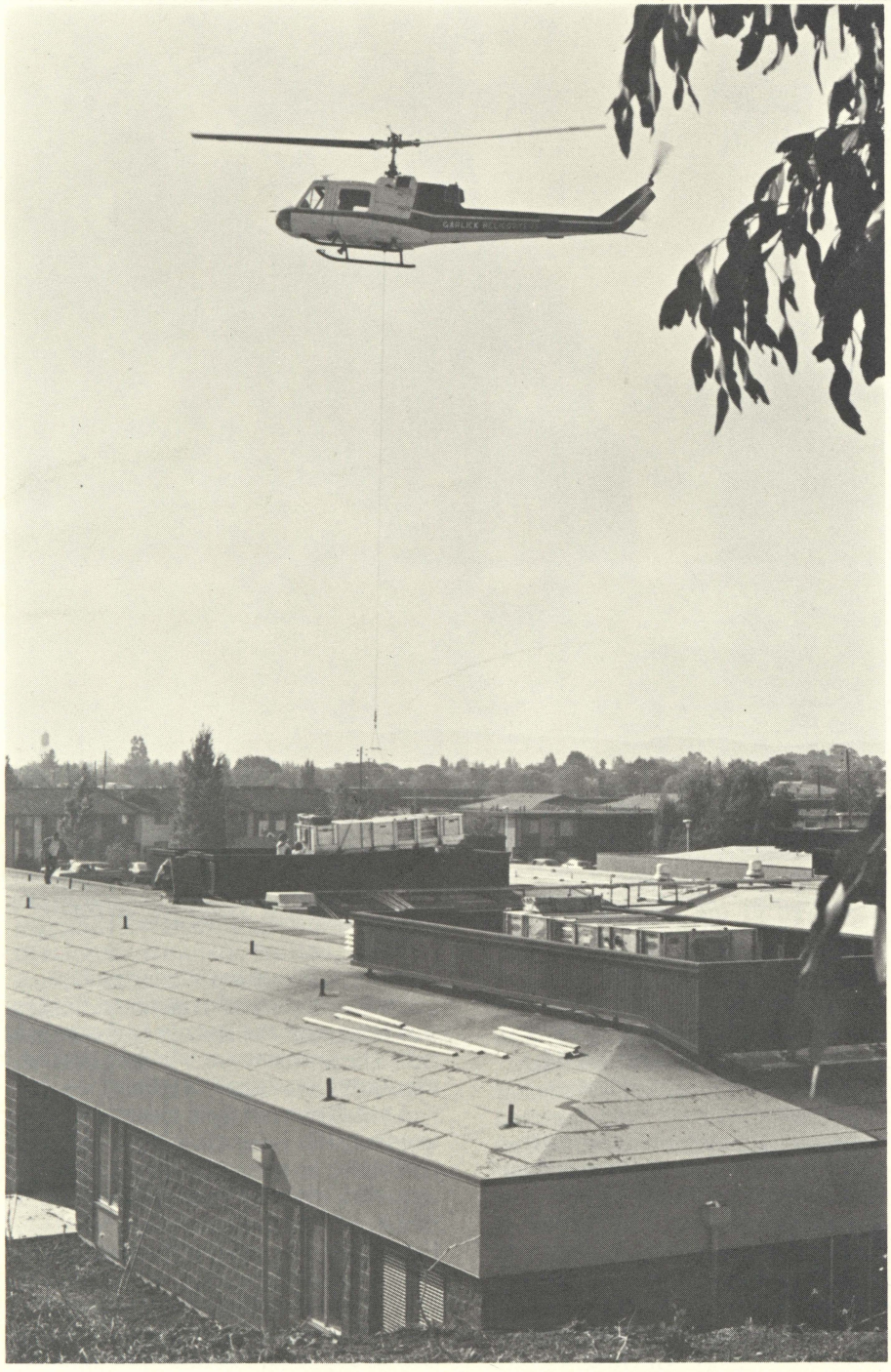


One of the final touches for Intercommunity's new patient care wing arrived by air in November. It was a 3,800-pound air conditioning unit which was set atop the hospital by a Garlick Aviation helicopter.

New wing to open

It took 18 months to gain state approval for it and more than a year to build it, but on December 15 Intercommunity Hospital's new 32-bed patient care wing is due to open right on schedule. The public is invited to help celebrate the event at 10 a.m. with a short ceremony, tours and refreshments.

"We want to invite all of the people in this area who really care about having a good hospital here," said Administrator Terry Pitts. "Many of those friends of Intercommunity contributed to the tremendous community support that helped this project gain approval. Many also donated the dollars that helped build it. Now we'd like to say thanks to those people. We want them to share in the happy outcome of all their efforts."

The $1,468,000 addition on the east side of the hospital will undergo final inspection by state Health Facilities Evaluator Bill Uhrig of the State Health Department Licensing Division on December 13. "He will authorize the opening of the wing and give us a punch list of small changes that we have six weeks to complete," said Chief Engineer Ed Smith. "We don't expect any major problems because all of our inspections so far have been fine." The 13,900 square foot nursing wing could receive its first patient the next day if all goes well.

The nursing area includes a 2,500 square foot, six-bed unit, specially equipped for children from infancy to age 14, including youngsters whose conditions require intensive care.

The adult section of the unit will serve 26 medical and surgical patients and has three rooms designed to meet the needs of the handicapped adult.

Victims on the way. . .

Emergency Room physician Bruce Baldwin evaluated incoming "wounded" as they arrived at the ambulance entrance in vans from a supposed terrorist bomb explosion at a high school.

The call came in on the Emergency Room Med Ned radio at 11:46 a.m. Simultaneous bomb explosions were expected in two schools, one in Vallejo, the other in Fairfield. "Evacuation," the crackling voice said, "cannot be accomplished in time to get all the students to safety. Go to phase I alert. Expect 20 casualties."

The number was wrong -- it almost always is because the first person on the scene of a disaster can't stop to count the wounded. The drill for disaster readiness was realistically underway. The second call came: Phase II alert. A more accurate estimate of casualties was directed to ICH, 25 this time.

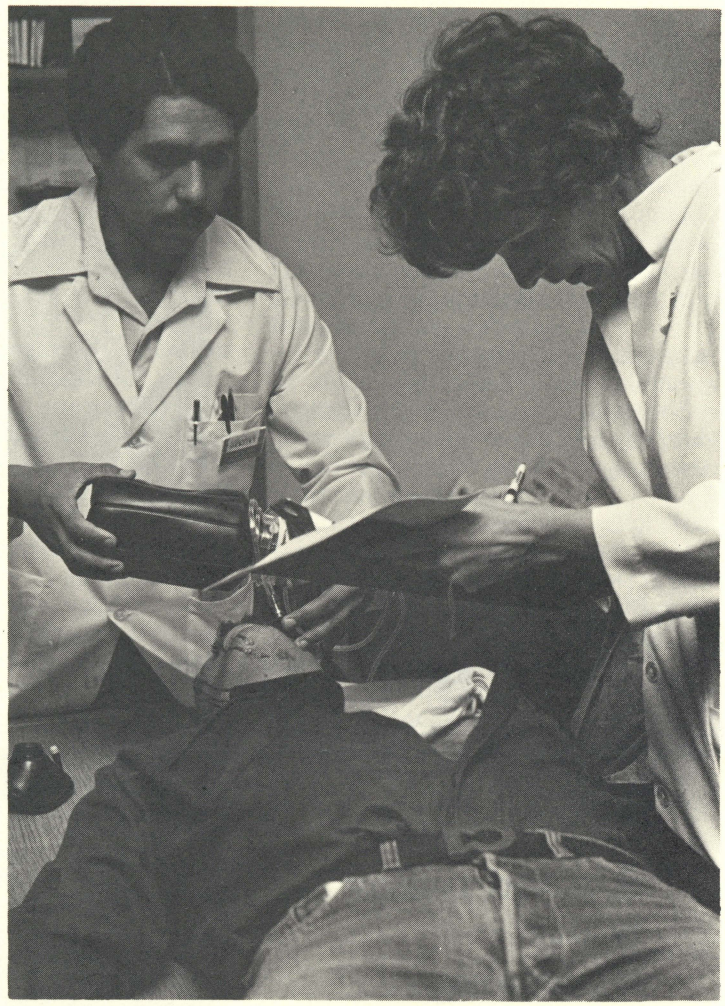
The switchboard operator paged a Triage II code alert to hospital staff. It was nearly noon on Thursday, November 15.

Physicians, finishing up their morning office appointments in Fairfield and Vacaville were called and asked to report to the physicians' lounge for assignment. Only a handful of doctors were inhouse, so head nurses stepped in to begin assessing which inpatients could be transported out to make room for wounded. Victims with heavy trauma were expected: burns, broken bones, head and internal injuries.

A quick bed-count showed only four beds available in the hospital's medical-surgical units. Critical Care had seven. Five more were open for pediatric or maternity patients. Surgery was busy and the Recovery Room was full. The problem was where to put the moulaged (made up) "victims".

At 12:20 p.m. they began arriving by van from the fire station where they had been "punctured, charred and bloodied" by expert moulage artists. Dr. Gary Neal, chairman of the Emergency Room and Disaster Committee assigned Emergency Room Chief Physician Bruce Baldwin to triage the incoming wounded. To triage is to quickly examine and evaluate the patient, then decide to which area of the hospital he or she should be sent based on the severity of injuries and the treatment required.

At left, Emergency Room Head Nurse Nancy Meagher tagged a victim for identification before he was transported to a treatment area. At right, surgeon Ingrid Chyba wrote orders for a patient as Respiratory Therapy Tech Armando Perez helped him breathe.



Outpatient clerks were called in from home to begin transferring the triage physician's orders onto patient ID tags and flow sheets as he worked over the victims. Runners, drafted from various hospital departments, put on green armbands to identify themselves and wheeled victims to assigned units or destinations.

Flow sheets showing basic information on victims to be admitted were circulated to departments every twenty minutes. On the units nurses went through the motions of pulling the charts of patients who could be safely transported to convalescent hospitals for the duration of a real disaster.

The lab, which had assessed its blood supplies and put in a hurried mock telephone request for more, began getting requests from physicians. Lab techs went out on the floors to simulate taking blood samples and began cross matching.

At the command post in Administration, Nursing Director Alison Esparza staffed the Labor Pool where employees reported for various assignments and kept her finger on the pulse of the entire hospital response. Medical Records Director Mary Roberts checked off the names of physicians as 17 of them arrived to assist.

Guild volunteers in uniform staffed hospital entrances and Junior Volunteers acted as "inpatients" who would be sent out to the convalescent homes.

By 1:28 p.m. the drill was completed. Evaluations were scheduled for the following week to determine whether the exercise had been effective at ICH and countywide. Recommendations for staff training and changes to the hospital's plan would come out of those evaluations so that ICH could respond even more effectively during the next drill, or real disaster.

The Joint Commission on Accreditation of Hospitals requires that two drills be completed every year.

"During a drill we draw as much as possible on our staff and supplies as we can without endangering any of our real patients," said ICH Disaster Response Chairperson Nancy Tubbs. "It was impressive to see that actual emergency patients were being treated by staff who didn't miss a beat; on one unit three critical medical situations occurred, patients were being admitted to units, and the staff just kept coping beautifully."

"We are fortunate to have medical staff members who respond enthusiastically, hospital employees and volunteers who take this training process seriously and committee members who have the hard job afterwards of deciding what needs to be changed or improved," she said.

Planning

Look for new surgery program in our future

For many patients, surgery will be a simpler, less expensive proposition at Intercommunity Hospital by next year. An expanded short-stay surgery program, which is in the final planning stages here, will allow more patients to undergo low-risk operations and be back in their own beds that night instead of in the hospital.

Procedures which are commonly performed in short-stay surgery include the removal of benign tumors, breast biopsies, minor ear nose and throat procedures, diagnostic surgical procedures called "endoscopies," therapeutic abortions and vasectomies.

The formalized program will be a major expansion of existing short-stay and outpatient surgery at Intercommunity, said Administrator Terry Pitts. Presently about 40 patients a month use these options. They can safely go home the same day after a few hours' observation by staff in the Recovery Room or additional time on one of the Nursing units.

Because a special staff and a specific room will be designated for the expanded program, about five to six patients a day will be able to use this option.

High quality care, patient comfort and convenience will be emphasized, said ICH Nursing Director Alison Esparza. A Registered Nurse will be in charge of the patient's care before and after surgery. The streamlined visit, including paperwork, lab tests, preoperative preparations, surgery and recovery will take four to seven hours. "Not only will the short-stay option be less expensive for some patients, but we expect that it will make a much smaller intrusion into their lives," Mrs. Esparza said. "They can get back on their feet and home with the family that night, and that's important."

What's Cookin'?

"A good recipe is like a blessing..."

Co-editor Martha Orr says the Guild recipes fit into nearly every menu.

The cook who loves travel, chocolate mousse, an occasional diet and a little suspense is going to eat "The Guild Cooks" right up.

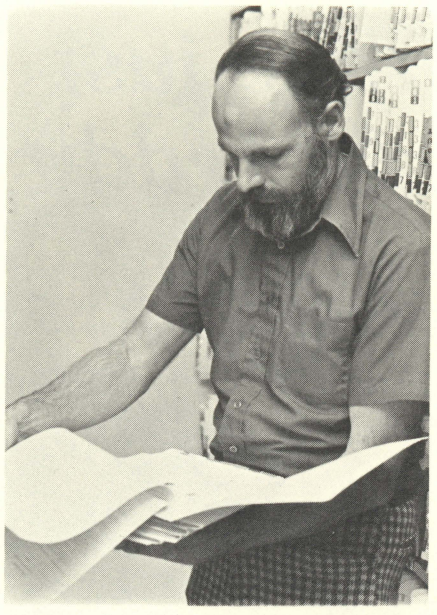
- Many of the 319 recipes are from around the world, Greece, Nigeria, China, Canada, Korea, Mexico, Tahiti, France, Russia, Germany, Italy, Sweden and of course, the USA.
- There's a recipe for Chocolate Mousse for One or Two, guaranteed to satisfy any chocolate-lover's craving for 24 hours, or until the second serving, which ever comes first.
- For the brief diet that must invariably follow, there's a sugarless Persimmon Nut Bread, super salads and a Tangy Lo-Cal Dressing.
- As for the suspense, the chefs in charge of "The Guild Cooks" are waiting to see how close cookbook sales will bring them to the Guild's long-term goal of raising $200,000 for the hospital's building projects.

Co-editors Juanita Tomasini and Martha Orr designed the $5.85 book for the average cook who wants to diversify a menu with a new entree or a special dessert, salad, sauce, soup, bread, vegetable, appetizer or beverage.

The book is on sale in the hospital at the Guilded Cage gift shop and at the Guild Thrift Shop at 535 Jackson St., Fairfield.

Volunteers

Look who's joined the ICH Guild



Howard Mortenson found his niche in Medical Records.

Howard Mortenson calls himself a workaholic who likes to do meticulous jobs. If so, he's certainly found his niche in Intercommunity's Medical Records Department as the hospital's first man volunteer. That Howard is the husband of Mary Roberts, the director of that department, played no small role in his volunteering for duty among the files.

Mary started some major reorganization projects when she became the department's director in May. She was spending about 13 hours a day on the job, so Howard decided to come in during the evenings to help. "Otherwise," he said, "I'd never see her."

Howard, who has his own business in Benicia restoring antiques, is helping to set up an inventory system, pulling charts and has reorganized the files to run vertically rather than horizontally.

For Guild President Barbara Walters, Howard's presence in the traditionally all-woman organization is a step in a new and positive direction.

"I think it's a good idea," she said. "I think that some male volunteers might be able to relate to the men patients better than women could. I'd especially like to see some of the retired gentlemen in the community join."

The Guild volunteers can select from a number of duty areas which include working with patients, helping out in various service departments and staffing the Thrift Shop and gift store. The Guild is a 325-member hospital support group which has been active at ICH for 22 years.

The Junior Volunteers, made up of teenagers of 14 to 18 years of age, also accepted their first male volunteer this year, 17-year-old Mark Stockbridge.

Patient information

New handbook has all the answers

Can my children visit me?

Do I have to wear one of those hospital gowns?

Will I get stuck eating Jello every day?

Intercommunity's new handbook for patients has the answers. (Yes...NO ...and Nope, even patients on restricted diets can choose their meals daily).

The 12-page booklets available to patients beginning this month were designed to answer the questions and concerns of the person checking into Intercommunity, said Community Services Coordinator Nancy Tubbs.

"Many patients will even receive parts of the booklet before they get to our front door. Doctors hand out the pre-admission portions in their offices so that patients can complete much of the paperwork, get their lab tests done and know what to expect before they come in for surgery or to deliver a baby."

Topics include what to bring to the hospital, an introduction to the staff, hospital services and procedures and a discussion of patients' rights and responsibilities.

The booklet lists visiting hours in various areas of the hospital and suggests a number of courtesies for guests to observe. Diet counseling, meal times, volunteer services and the hospital's pastoral counseling program are discussed.

Patients are also encouraged to complete a short survey enclosed in the booklet. The responses help Intercommunity staff to evaluate the services provided and make the changes needed to keep the quality of care high at ICH.

Pediatric orientation

"I'm brave just like that teddy bear."

Diane Gagliano, R.N., takes Teddy along on children's tours of the hospital. Here the youngsters learned to work the controls on an adult-sized bed where a young patient might stay if the Pediatric Unit was full.

Six-year-old Heather McDonald cheerfully showed the anesthetist where to give her the preoperative injection for a routine tonsillectomy. "Don't forget to save my tonsils!" she called out as a nurse wheeled her into surgery.

"She didn't even cry from the shot," said her surprised mother, Donna McDonald. "She was very comfortable and familiar with everything beforehand."

Heather was prepared for her hospitalization by Intercommunity's Pediatric Orientation Program. Registered nurses Elaine Kramer and Diane Gagliano, who recently earned degrees in child development, started the program at ICH in September.

Youngsters from toddlers to preteens can attend the orientation on the Sunday preceding their elective surgery.

The children and their parents view a slide show illustrating a child's typical hospitalization. It follows young patients from the admittance procedures to the Laboratory for blood tests, to Radiology for x-rays, into the Operating and Recovery rooms and Pediatric Unit.

A Pediatric nurse then takes the families on a hospital tour. A favorite "patient" such as a teddy bear always goes along to get a blood test in the lab.

"Kids have very big imaginations," says Pediatric Head Nurse Christi Landis. "They think they're going to die or that the doctor will cut their throat to take out their tonsils. The purpose of the orientation is to tell them exactly what will happen. They will expect to get shots and have an intravenous tube that is attached to an I.V. bottle. They're warned that they'll hurt after surgery, and they know what kind of bed they'll be in."

Lark Freeman, 5, underwent eye surgery, just as her mother had at the same age. Unlike her mother, Lark "liked the hospital." Mrs. Freeman recalled, "my surgery was a very traumatic experience. I had very negative feelings about hospitals for years afterwards. Lark enjoyed the orientation because she saw all the other children there and realized that she wasn't the only one going to have surgery."

After the hospital tour, the children have a chance to inspect an I.V. set-up, try on oxygen masks, surgical gowns, masks and caps. During this play session the teddy bear gets a work-out. The kids bandage him with gauze and adhesive tape. Parents, brothers and sisters are enlisted as "patients" so junior medics can practice listening with stethoscopes and giving shots with needle-less syringes. The fun concludes with snacks for everyone.

"Familiarity with the situation takes out a lot of the fear," noted Heather McDonald's mother. "I like the way the nurses level with the kids and tell them they'll be sore. Honesty is important."

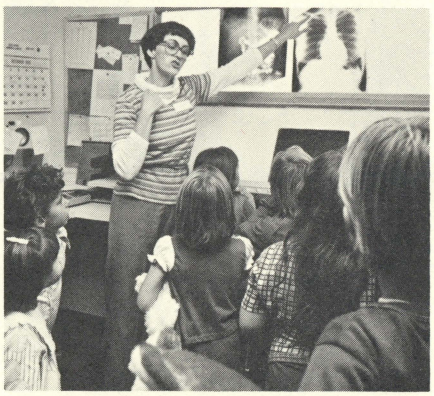
Before the orientation, nine-year-old Tammy Hammon "was scared to death," recalled her mother, Carol Hammon. "Now she tells her brother, who has to have his tonsils out, that 'there's nothing to it.' She didn't move, scream or cry when she had her blood test. She said, 'I'm brave just like that teddy bear.'"

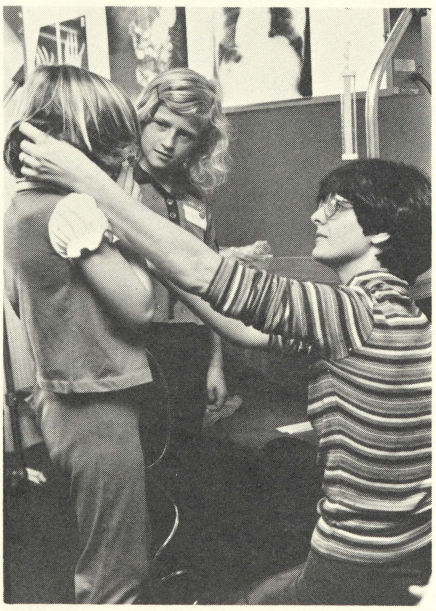
Mrs. Landis says that she and her staff have found that since the orientation program began, "the kids have been easier to reason with because they know what's happening. They feel more in control of their situation. The I.V. doesn't scare them, and they don't scream about their sore throats because they've been forewarned. The parents are less apprehensive too."

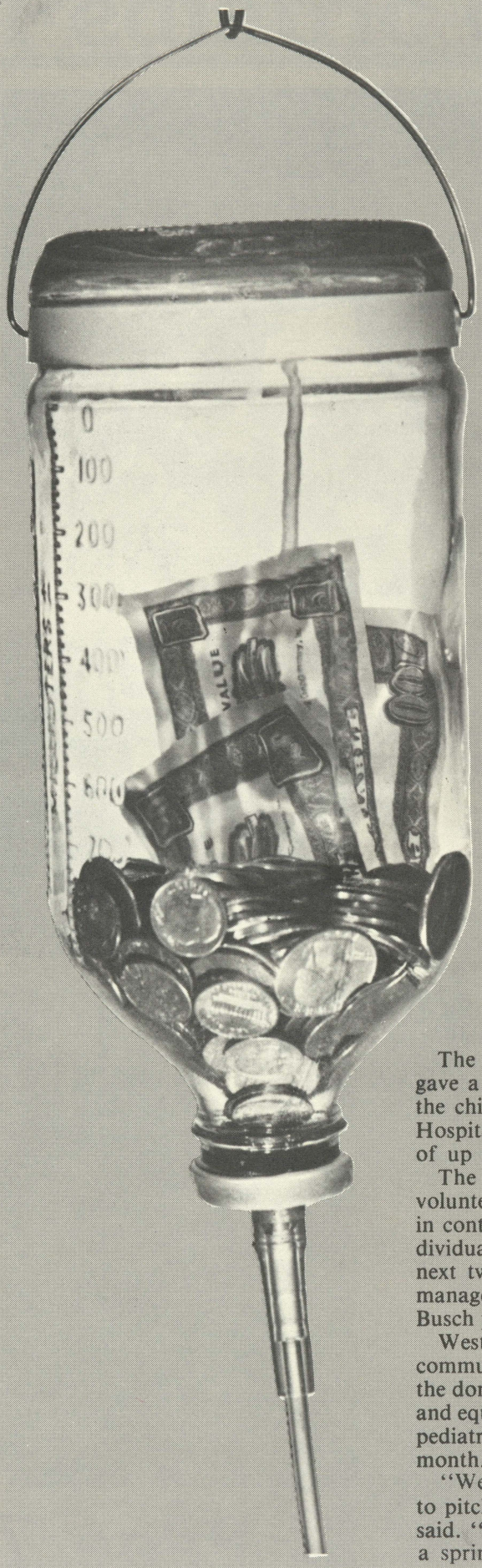
At top, Tammy performed a check-up on her dad and mom, Jerry and Carol Hammon.

"This is what it looks like on an x-ray," Diane told children scheduled for surgery, at right.

Below, Tammy watched as Elaine Kramer, R.N., helped Heather McDonald try on an oxygen mask.







Donors make it happen

The Anheuser-Busch Foundation gave a dramatic boost to funding for the children's unit at Intercommunity Hospital in September with a pledge of up to $25,000 in matching funds.

The St. Louis-based foundation volunteered to match up to $25,000 in contributions to the hospital by individuals and organizations over the next two years, said George Weston, manager of the Fairfield Anheuser-Busch plant.

Weston, a member of the Intercommunity Board of Directors, said the donation will help finance facilities and equipment in the hospital's six-bed pediatric unit which will open this month.

"We also want to encourage others to pitch in and help the hospital," he said. "Our offer of matching funds is a springboard to get the ICH development program off the ground."

"I think it is important to make this kind of committment for the same reason I serve on the hospital board. Intercommunity is one of the resources upon which our employees and their families depend. It's our primary source of health care, especially when our employees need emergency treatment."

The donations and matching funds will be handled by Intercommuntiy Development Program coordinator Marilynn Harris.

"This is really a boost to the new fund raising effort we will be developing at Intercommunity during the next year," Mrs. Harris said. "We are very lucky to have the support of George Weston, who brought the hospital's needs to the attention of the Foundation."

During 1978 Anheuser-Busch, the Anheuser-Busch Charitable Trust and the Anheuser-Busch Foundation contributed $1.4 million to organizations active in the fields of education, health care, projects for minorities and environmental protection nationwide.

Mrs. Harris announced the following additional contributors to the ICH Development Program:

BEQUEST

From the estate of Nellie M. Mack, a will bequest of $1,000 to Intercommunity Hospital.

NEW PLEDGES

Fairfield Elks Lodge No. 1976
Northern Solano County Board of Realtors
John H. Rainey

NEW FOUNDATION MEMBERS

Jean and Paul Krause
Eva C. Olson
Fairfield Elks Lodge No. 1976, Exalted Ruler
Cecile Buzzini
Al Podkin

MEMORIALS

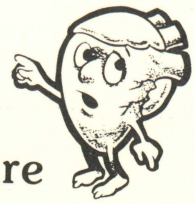
For **Leona Herbert** by Mr. and Mrs. Lewis Pierce.

For **John P. Buzzini** by Mary and and Eddie Noonan and Cecile Buzzini.

For **Peggy Foxman** by the Intercommunity Hospital Guild.

For **Russell Beelard** by Dean and Ann Anderson.

LIFESAVERS



What you should know about high blood pressure

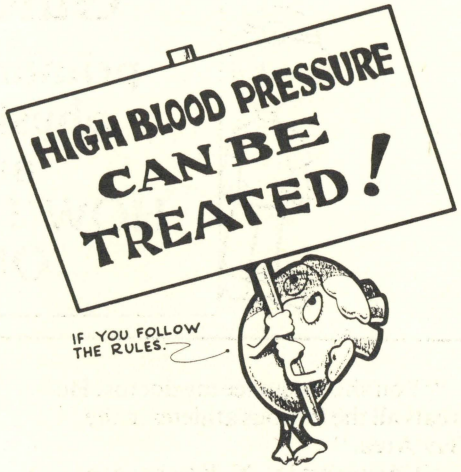
Modern myths would have us believe that high blood pressure, called hypertension, is a stress disease. They say we get it from overwork, no exercise, three-martini lunches, junk food and too many cigarettes. The fact is that physicians don't really know what causes high blood pressure in most cases, although heredity may be a factor.

They do know that 35 million Americans, about one in six, have high blood pressure and that only a small percentage of those are being treated.

Most health care consumers do not realize hypertension is a killer; it leads to heart failure, stroke, kidney damage and more. High blood pressure adds to the workload of the heart and arteries. Forced to pump harder than normal over a long period of time, the heart tends to enlarge and eventually has a hard time keeping up with the demands being put on it.

After the wear and tear of years of high blood pressure, the arteries and arterioles may become hardened, less elastic and scarred. They may not be able to deliver as much blood as the body's organs need to function well. Or a blood clot may lodge in a narrowed artery and deprive part of the body of its normal blood supply. The possibility of blood vessel damage in the brain, a stroke, is also increased with high blood pressure.

Treatment for high blood pressure can dramatically reduce the risk of a stroke. Widespread effects on the heart, kidneys and nervous system can be prevented or reduced if the elevated blood pressure is treated early, before functions become impaired, and if treatment is maintained.



Here are the keys to coping with the risk of high blood pressure.

1. Get your blood pressure checked. Do it even if you feel fine. Symptoms aren't always noticeable.

2. If you have hypertension, follow the diet your doctor recommends. Don't change your diet until you've consulted with your doctor.

3. Lose weight if your doctor believes you should.

4. You may have to decrease the amount of fat in your diet.

5. Avoid self-medication, but faithfully take the medicine prescribed for high blood pressure.

6. Get plenty of rest.

7. Avoid alcohol and tobacco.

8. Settle your problems so they don't worry you and interfere with your peace of mind.

9. Get plenty of sleep, even if it means taking a nap during the day.

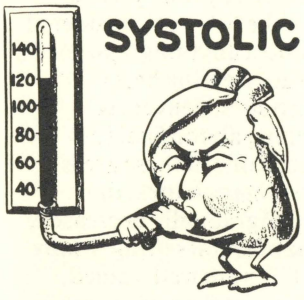
Just what is blood pressure?

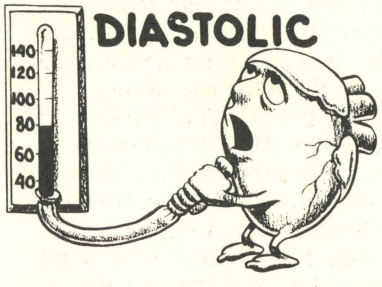
Everybody has blood pressure. Without it, blood wouldn't circulate through our bodies. When a professional takes your blood pressure, she or he measures the force of the blood against the arterial walls as it is pumped by the heart.

Arterial walls are elastic and muscular. They stretch and contract to take the ups and downs of blood pressure. Each time the heart contracts, about 70 to 90 times a minute, blood pressure in the arteries increases; each time the heart relaxes between beats, blood pressure goes down. These two levels are called "systolic", when the heart contracts, and "diastolic", when it is relaxed.

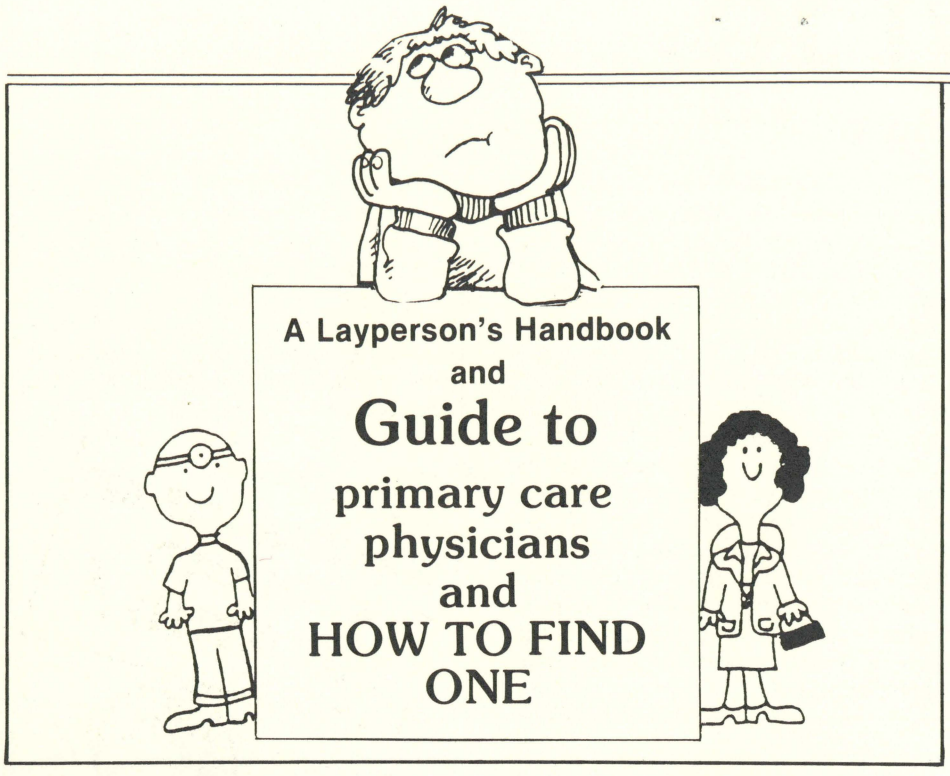
Average systolic blood pressure is about 120 millimeters of mecury, and average normal diastolic pressure is about 80 millimeters of mercury. This is reported as 120/80 or "120 over 80".

For the average person, when the diastolic pressure reaches 90 or higher, it is said to be elevated.





Because not everybody is average, a person's normal reading may be higher or lower than 120/80. Once the individual's normal blood pressure is established, deviations from it can be better understood.



"You should go see my doctor. He treats all the famous athletes in the Bay Area."

"I'd suggest Dr. X. You have to wait a month to see him, so he must be good."

"I've never felt better since I started going to that doctor down the street. My headaches use to kill me. Why not try her."

"I never bothered to get a doctor. You can always use the emergency room, you know."

Good advice? Which alternative would you choose, or would you do some more checking around before you decided on a physician for yourself or your family?

The fact is that most health care consumers do less research and shopping to find the right doctor than they do before buying a new car. But then, there are readily available consumer magazines about automobiles. And most people are more comfortable driving a demonstration model around the block than they are "trying out" a doctor.

Yet that's exactly what several local doctors and authors of three books for health care consumers suggest when you're in the market for a new primary care physician. After all, choosing a doctor is a first step in entering the health care arena. It's a decision that can have far-reaching consequences.

First, who are the primary care physicians, the ones a patient will go to directly without a referral from another doctor?

GENERAL PRACTITIONERS--the role of the GP has gone through tremendous changes in the last 50 years. Once, backed by four years of medical school, the title was considered license to do almost anything a physician wanted to do, treating heart attacks, setting bones, delivering babies, performing abdominal surgeries. When each one of these areas developed into subspecialties, the domain of the GP gradually decreased, especially in the hospital setting. Many of the oldtime GP's are well trained, and their care is more than adequate for routine illness, while critical and complex illnesses are handled by practitioners of the newer specialties.

FAMILY PRACTITIONERS -- This group was officially established in America in 1969 for physicians who are better trained in specific areas than the traditional GP and are more concerned with the total care of the family unit than today's specialists. After medical school, the family practitioner completes a residency program in areas such as internal medicine, pediatrics, and the office practice of gynecology and orthopedics. A smattering of the dozens of topics this physician studies includes family structure and function, preventative medicine, sexual counseling, psychiatric referral and learning disorders in children. This physician seeks to look at the patient's and the entire family's medical problems in the context of their life histories and environment.

INTERNISTS -- General internists treat a wide range of nonsurgical problems. They are qualified by three years of internal medicine residency and subspecialty training of an additional one or more years of "fellowship". These physicians may have subspecialties in many areas including diseases of the heart, endocrine organs, the gastrointestinal tract, the blood, lungs, kidneys and other areas.

OBSTETRICIANS-GYNECOLOGISTS -- This specialty group treats conditions affecting the female reproductive system (gynecology) and the delivery of pregnant women (obstetrics).

PEDIATRICIANS -- These doctors specialize in care for children and adolescents. They may also subspecialize in such areas as pediatric cardiology or endocrinology.

Once a potential patient has some idea of what type of primary physician he or she wants to see, the evaluation process begins.

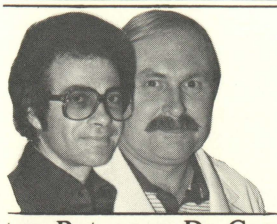
In "What You Should Know About Health Care Before You Call a DOCTOR!", G. Timothy Johnson, M.D., warns "You should understand that all states will license a physician to practice (if he can pass certain requirements) after four years of medical school plus one year of internship . . . Once licensed, a physician can call himself anything he wants . . . a cardiologist or a psychiatrist -- or even a surgeon."

The informed health care consumer can begin by looking at a physician's credentials. Most doctors post their credentials in their offices and are willing to discuss them with a new patient, says Dr. Percy George, a Fairfield internist.

Dr. Ronald Rushford, Vacaville Family Practitioner agreed. "It's even kind of disappointing when patients don't ask. If a physician is proud of his background, he's usually glad to talk about it. Yet many physicians have a general reluctance toward boasting and advertising. He may wait to be asked. A doctor's credentials may be one area of least exposure."

Items to ask about include schools attended, where and when internship and residency were done, specialty areas of interest or training, certification by a specialty board.

The local Medical Society and physician's office staff are able to answer these questions for patients



Should you look for a new doctor in the phone book, ask your friends or call the Medical Society? Drs. Ross, George and Rushford have some suggestions.

too. But, warns Dr. George, don't rely on the phone book; the phone company doesn't make someone prove his proficiency before they list him as a specialist.

The second round of questions gives a broader explanation of a doctor's range. Is he or she active on the medical staff of a good hospital with a strong peer review system? What are the limitations of the doctor's practice? Does he focus on some sub-specialties of medicine? What teaching appointments does she have? Does he complete more than the continuing education credits required to keep up to date on medical knowledge?

Some physicians spend a portion of the patient's first visit outlining their background and general information about their practice. "I'm always appreciative of the individual or family who comes in to meet me ahead of time." said Dr. Rushford. "And I don't think a physician should charge for a brief meeting."

Items to discuss at this point in the new physician-patient relationship include these suggested by Stanley E. Sagov, M.D., in the book, "The Active Patients' Guide to Better Medical Care".

"House calls and general availability -- Does the doctor make house calls? Are arrangements made for coverage during the doctor's vacation time? What about availability at night for emergency consultations?

"Fees -- How much for an office visit, general physical examination, follow-up visits, telephone consultations, surgical procedures?

"Laboratory tests -- What tests can be done right in the office? To which lab are tests sent? Ask whether the doctor's bill will include the cost of lab tests or whether you will be billed separately by the lab.

"Office set up -- Number and type of professional, paraprofessional, and secretarial staff. Ask how you would be able to make use of their services. Who schedules appointments? What's the average waiting time for an appointment? In the waiting room?

"Drug prescribing -- What are the doctor's general attitudes toward the use of high-powered drugs for symptomatic relief? Does the doctor automatically and invariably prescribe drugs, or is there a more conscious and discriminating selection of that form of treatment? Are drugs prescribed by brand names or by their generic names?

"Affiliation with hospitals -- Does the doctor have privileges, i.e., the right to admit and treat patients in an accredited hospital?

"Philosophy of practice -- Conservative vs. agressive approach to illness; frankness vs. secrecy; preventative attitude toward health care vs. crisis or episodic treatment of illness."

"For many patients in our area philosophy of the physician is very important," said Obstetrician-Gynecologist Philip Ross, who practices in Vacaville. "The patient who wants a home delivery is going to be looking, primarily, for a doctor who does home deliveries. Other factors become much less important to that person."

The rapport that develops between physician and patient is probably the single most important factor to patients, he suggests, even more important than a physician's credentials. "If you don't know anything about medical schools, how do you know which ones are good in the first place," says Dr. Ross who took his medical training at the University of Southern California and his residency at Stanford Hospital. "Someone hears a doctor was 'Stanford-trained' and they're impressed; they think everyone who comes out of Stanford is good. They forget that people graduate from the top or bottom of their classes."

"It's safer to look at the quality of the individual who took the training than to just focus on the training."

Dr. Ross suggests that in the area of patient-physician compatibility, personal recommendations from close friends are a good place to get information about a new doctor.

Dr. Johnson, author of "What You Should Know...", suggests, however, that advice from friends be carefully evaluated... the personality of a physician is important, but not as important as the knowledge between his ears.

Patients shouldn't be afraid to shop around a little to find the right physician, Johnson suggests. Without encouraging doctor-hopping, he reminds patients that they're not married to a physician who doesn't fill their needs. Discreet changes can always be made.

For the family new in town, the single most valid referral may be one from the doctor back home, says Dr. George. Good doctors seem to know physicians of the same calibre in other parts of the country.

Suppose you don't have a doctor and a medical emergency comes up -- a broken leg on the ski slope, or an appendicitis attack in the middle of the night. Then the hospital emergency room is the best place to call. But emergency rooms are not geared for on-going care. They require intensive staffing and expensive equipment which makes the cost for a single visit higher than one to a personal physician.

If you don't have a primary care physician, odds are you'll need one some day, and that may be the worst time to start looking. You may notice a funny lump where it doesn't belong, develop chronic stomach cramps or a sudden attack of fever or chills. If you've selected your primary care physicians, the next step is easy. No time is wasted calling friends, asking for advice, asking about credentials or fees. Just pick up the phone and call your own doctor, the one who knows you and your medical history, the one you know and trust.

References

Solano County Medical Society
733 Tuolumne St., Vallejo 94590
642-9202

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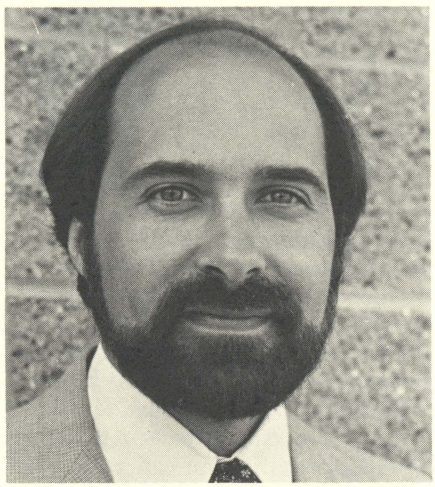
What's new and who's new

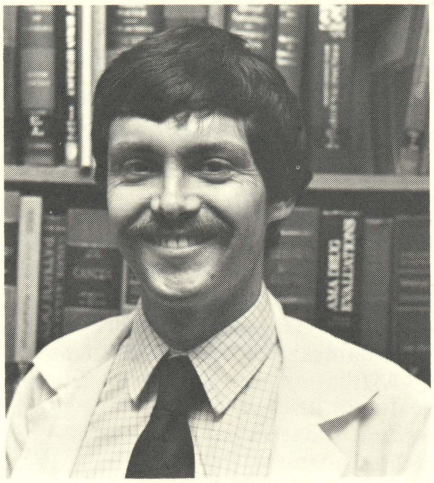


Intercommunity Administrator Terry Pitts has been elected secretary-treasurer of the tri-county North Bay Hospital Conference for 1980.

The Conference is comprised of representatives of hospitals and health-related organizations in Solano, Sonoma and Napa counties.

Its objectives are to promote planning and coordination of community hospital services, and to serve as a forum for issues and a clearing house for information on the advancement of health care services.

The Conference is affiliated with the American Hospital Association and the Hospital Council of Northern California.



In pursuit of his degree, Dr. Daniel Green, general internist, did a month's internship in an Alaskan hospital 500 miles west of Anchorage. "There were no roads, so I flew to the Eskimo villages with bush pilots in little, single-engine planes. The hospital served a 1,000-square-mile-area," he said.

The Alaskan adventure and three months in the Oncology (cancer) Department of Harvard Medical School were part of his training from U.C.L.A. Medical School. After completing a residency he joined Fairfield Clinic where his father, Dr. Allan Green, is also an internist.

Dr. Green finds his hometown of Fairfield "an ideal place to begin practice because there's a real need for my specialty." He chose internal medicine because to him, "it was the most challenging with so many new developments in the field. The patients are often seriously ill and require intensive care."

Many of his patients are elderly. "I've always respected older people and think they're often neglected by everybody including physicians. I like to listen to old people, they can tell you many things."

Dr. William Shakin is a new member of Intercommunity's physician staff and of Vacaville's medical community, but he has been a family practitioner in the Vallejo area for 11 years. "I was the first physician to do cardiology treadmill stress tests in Solano County in 1974," and I still do them in my office, Dr. Shakin said.

Since receiving his degree from the University of California College of Medicine at Irvine in 1962, he has served six years as chief of medicine at a Vallejo hospital.

Dr. Shakin swims and plays racquetball to keep his heart fit. What really quickens his pulse is a beautiful painting, intricately designed coin or uniquely sculptured bookend. "I have about 200 bookends, many brought back from travels throughout Europe."

His coins give him the greatest pleasure, partly because he enjoys the search for specific gold coins to complete a series. "I started collecting coins 25 years ago and have long sets dating back to the 1800's."

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House Call

House Call is published quarterly for the friends and employees of Intercommunity Hospital, 1800 Pennsylvania Ave., Fairfield, California. Address inquires to the Community Services Department.

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